

# Editorial

## Quality assurance in the day surgery setting

The fundamental concept underlying modern ambulatory surgery is that the care delivered to the day case patient should be of a high quality. It could be argued that in many ways the level of care should surpass even that delivered in the inpatient setting as any minor morbidity may assume greater importance once the patient returns home. Nowadays healthcare professionals are aware that quality of care ought to be assured or guaranteed. The fact that the practice of quality assurance is only slowly being adopted in British hospitals is largely due to the problems that accompany this necessary activity.

Future health systems will be concerned with quality service and cost-effectiveness. Information on what is being done, to whom, by whom and using what resources, will become important. It is envisaged that the new breed of managers will assume control of many aspects of clinical practice. These people deal in hard facts and figures, and the everyday jargon will be of performance indicators, monthly costings, and outcome measures. Modern day surgery units will require access to such information, thereby allowing them to plan accordingly for the future and to utilize their resources efficiently. Such information could assume greater importance to many units; after all it could secure their continued existence and prevent closure. In the past doctors and nurses have been rightly accused of 'shroud waving' in order to obtain funding for their various activities. In future this behaviour will be reduced as resources will only be allocated if a proven need exists. Briefly, audit could play an important role in any hospital environment by providing just such proof.

One exciting benefit to be gained from quality assurance will be the improvement in health care provision. Jacyna<sup>1</sup> has stated that an inferior level of care may be implied by the assurance of quality and the implementation of improvement. This is not necessarily so, as the reasons for failing to meet required standards of clinical practice are many and varied. Far too often in current quality assurance, the appropriate standards are as yet unknown. Although research may indicate an improved method of practice, this takes time to become standard practice. Audit of the progressive improvement in the standard of care that follows the implementation of research could prove an enlightening exercise.

Why has the implementation of quality assurance been so slow? Two major problems exist. First, problems surrounding methods of data collection remain to be solved. Although computers are neither necessary nor mandatory, they do offer considerable advantages for audit. For instance, vast amounts of information may be processed with accuracy, but the data has either to be loaded into the system by hand or collected in such a way as to enable optical mark reading. Another solution is to enter the data 'on line', i.e. directly, using hand-held personal computers. The latter could be the way of the future but at the time of writing is far from widespread practice.

The second problem associated with quality assurance is deciding what actually constitutes an indicator of quality. Some indicators are self evident, others are less so. Admission rates have always been considered a measure of good day surgical practice: only recently have re-admission rates assumed greater importance, and few units regularly monitor the late starting and finishing of lists, or the wastage of commonly used anaesthetic drugs. We believe the development of quality indicators for day surgery will be an ongoing process. It is conceded that the indicators used in some publications are open to discussion, but quality indicators which will measure how near or how far any individual day unit is from the prescribed targets will be demanded by future managers, general practitioners, and indeed, patients alike.

Quality assurance should not be confused with research or reviews. Research is the means whereby the ideal standards of practice are determined, whereas quality

assurance is the measurement of the gap between those standards and current practice. Undoubtedly research and quality assurance ought to go hand in hand but the third member of this trio, education, should also be considered. Education is the means by which the standards set by research and maintained by quality assurance are communicated to the next generation of clinical staff. As already stated, quality assurance also has another purpose, namely the highlighting of areas where change may be appropriate. Each subsequent cycle of the audit loop should in theory bring a continued improvement in patient care, just as each generation of health practitioners have their own contribution to make. If we are truly committed to the provision of excellent health care in the field of day surgery, then quality assurance should hold no terrors for any of us. However we do have a duty to ensure that the quality assurance programmes we embark upon are meaningful, and fulfil their designated purpose. Finally we believe that all members of a day surgery unit should be involved in audit activities and the papers appearing in this edition will outline some of the benefits and pitfalls which may arise if an active clinical audit programme is instituted. There are tremendous benefits to be gained for all concerned.

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#### **References**

- 1 Jacyna MR. Pros and cons of medical audit . . . A conversation with a sceptic. In: *Hospital Update* 1992; **18**: 512-18